Kentucky Department of Veterans Affairs
Office of Kentucky Veterans Centers
1111 B Louisville Road
Frankfort, Kentucky 40601
Phone: (502) 564-9281 FAX: (502) 564-4036

Dear Potential Resident/Family Member:

Thank you for your interest in the Kentucky Veterans Centers. We realize that the decision to place a loved one into a long-term care facility is not an easy one, and our goal is to make the transition as effortless and pleasant as possible.

At the top of the enclosed application you will find the names of the three state veteran's nursing homes we operate. Please check the box beside the home or homes in which you are interested in applying for admission.

There are admission coordinators at each home who are trained to assist, guide, and direct you through the application process. The address and telephone numbers of the admission coordinators are listed below, and we encourage you to contact them for any assistance needed.

In order to expedite the process, we have attached a list of items that are needed to help determine your eligibility, level of care, and financial responsibility. Please forward these items to us along with your completed application. Again, if any assistance is needed, please do not hesitate to contact one of the below facilities.

Thomson-Hood Veterans Center	Eastern Kentucky Veterans Center	Western Kentucky Veterans Center
ATTN: Admissions Coordinator - Gretchen Davis **Financial – Michael Horton**	**ATTN: Admissions Coordinator – Ray Collins** **Financial - Nikki Begley**	**ATTN: Admissions Coordinator – Lisa Ware** **Financial – Lisa Foster**
100 Veterans Drive	200 Veterans Drive	926 Veterans Drive
Wilmore, KY 40390	Hazard, KY 41701	Hanson, KY 42413
859-858-2814	606-435-6196	270-322-9087
800-928-4838	877-856-0004	877-662-0008
FAX 859-858-4039	FAX 606-435-6201	FAX 270-322-9497
TTYS 859-858-4226	TTYS 606-435-6203	TTYS 270-322-9752

We appreciate your service to the nation and extend our gratitude for the opportunity to serve you, the veterans of America's Armed Forces!

Sincerely,

Mark Bowman

Mark Bowman, Executive Director
Office of Kentucky Veterans Centers

☐ Thomson-Hood Veterans Center
100 Veterans Drive
Wilmore, Kentucky 40390

☐ Eastern Kentucky Veterans Center
200 Veterans Drive
Hazard, Kentucky 41701

☐ Western Kentucky Veterans Center
926 Veterans Drive
Hanson, Kentucky 42413

Please place a check in the box next to the home you are interested in.

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the Kentucky Veterans Centers.

INSTRUCTIONS:

1. Applications must be TYPEWRITTEN or PRINTED IN INK.
2. Applicant must be a veteran, be disabled by reason of disease, wounds, age or otherwise is in need of nursing care
3. Applicant must be a resident of Kentucky as of the date of admission to a Kentucky Veteran Center
4. Applicant must have a military discharge that is not of a dishonorable nature

COUNTY OF RESIDENCE: Where is the veteran currently living/receiving care	DATE:

In compliance with the eligibility requirements, I do hereby apply for admission to the Kentucky Veterans long term care facility checked above, and declare the following statements and information to be true:

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET OR RFD)	TELEPHONE NUMBER
CITY, COUNTY, ZIP CODE	

DATE OF BIRTH	SEX	AGE
PLACE OF BIRTH		RELIGION

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED (PLEASE PROVIDE DATES AND COPIES OF EACH)
☐ WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE)
☐ LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)

NAME OF SPOUSE (maiden name)	SPOUSE'S SOCIAL SECURITY NUMBER
SPOUSE'S ADDRESS	SPOUSE'S DATE OF BIRTH

DATE AND PLACE OF MARRIAGE (PLEASE PROVIDE COPY OF MARRIAGE LICENSE)

MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge)

BRANCH AND SERVICE NUMBER	DATE AND PLACE OF ENLISTMENT	DATE AND PLACE OF DISCHARGE	TYPE OF DISCHARGE

IF YOU HAVE EVER BEEN A RESIDENT OF THE KENTUCKY VETERANS CENTER OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:

DATE OF DISCHARGE	FACILITY	REASON

HAVE YOU BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST SIX MONTHS? ☐ Yes ☐ No
If Yes, please complete the following:

Name of Hospital/Private Physician	Address of Hospital/Physician
Name of Hospital/Private Physician	Address of Hospital/Physician

DO YOU HAVE MEDICARE? ☐ YES ☐ NO PART A_____ PART B_____ EFFECTIVE DATES: _____ MEDICARE NUMBER _____ (Provide copy)	DO YOU HAVE MEDICAID? ☐ YES ☐ NO MEDICAID NUMBER_____ (Provide copy)
DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE: ☐ Yes ☐ No COMPANY AND NUMBER_____ (Provide copy & verification of premium due)	DOES YOUR SPOUSE HAVE ANY OTHER HEALTH/MEDICAL INSURANCE ☐ YES ☐ NO COMPANY AND NUMBER_____ (Provide copy & verification of premium due)

INCOME AND ASSETS

FAILURE TO PROVIDE FINANCIAL INFORMATION OR TO ASSIGN BENEFITS (1)FAILURE OF THE RESIDENT TO DISCLOSE FINANCIAL INFORMATION REQUIRED TO COMPUTE HIS OR HER ABILITY TO PAY SHALL RESULT IN THE RESIDENT PAYING THE MAXIMUM CHARGE FOR ROOM AND CARE; (2)IF THE RESIDENT OR PERSON RESPONSIBLE FOR THE RESIDENT FAILS TO SIGN THE ASSIGNMENT PROVISION CONTAINED IN THE PATIENT OR RESPONSIBLE FINANCIAL AGREEMENT, THE MAXIMUM CHARGE FOR ROOM AND CARE SHALL BE ASSESSED.

SIGNATURE **DATE**

YOU WILL BE CHARGED ON YOUR ABILITY TO PAY UP TO $3700 PER MONTH. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

LIST ALL REAL ESTATE YOU AND/OR YOUR SPOUSE OWN OR IN WHICH YOU AND/OR YOUR SPOUSE HAVE ANY INTEREST. (Give location, size, description and approximate value. State whether held solely or jointly with husband/wife).

LIST ALL SECURITIES WHICH YOU AND/OR YOUR SPOUSE OWN. (Include cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money or securities. Give amount and where located). (Provide verification of all securities listed).

LIST THE PERSONAL PROPERTY WHICH YOU AND/OR YOUR SPOUSE OWN. (Include auto, truck, livestock, furniture, farm equipment, business inventory, etc. Give approximate value and where located).

LIST ANY INDEBTEDNESS OTHER THAN THAT SECURED BY YOUR PRIMARY RESIDENCE. (Include amounts, payee, due dates and reason for indebtedness).

LIST ANY INSURANCE POLICIES WHICH YOU AND/OR YOUR SPOUSE HAVE. (Include burial, life, hospital, health and accident. Give name of company and face and/or current cash value). (Provide copies).

LIST GROSS AMOUNTS OF MONTHLY INCOME:	VETERAN	SPOUSE
Wages	$	$
VA Pension	$	$
Service Connected Disability _____Percentage	$	$
Social Security	$	$
Medicare	$	$
Retirement Income	$	$
Pension Income	$	$
Other Retirement Income	$	$
Interest	$	$
Dividends	$	$
Income from rental properties	$	$
Court Mandated(Alimony, Child Support)	$	$
Other Income	$	$
Other Income	$	$

PERSONS TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached).	
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE
	CELL PHONE
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE

BURIAL ARRANGEMENTS

Name of Funeral Home
Funeral Home Address
Desired Location of Burial
Responsible Person for arrangements

CERTIFICATION

I_____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the facility. I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the Commonwealth of Kentucky and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the staff such transfer is necessary. This application is my free and voluntary act.

I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the Kentucky Veterans Center is subject to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the Kentucky Veterans Center.

I also understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.

I understand that non-medical leaves of absence from the facility in excess of twelve (12) calendar days per year will result in a charge of the regular monthly charge plus the current VA per diem rate in effect at the time of absence. Absences from the facility will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period.

I understand that the resident is allowed ten (10) consecutive days during medical leaves of absence (hospital stays). Medical leaves of absence may occur more than once in a calendar year. A hospital stay will be considered to have ended when the resident returns to the facility for at least a continuous 24 hour period. Resident/Responsible Party will be given the opportunity to continue to hold the bed at a charge of the monthly fee plus the VA per diem rate. In order to be eligible for a bed hold, the veteran must have established residency by being in the facility for thirty (30) consecutive days before leave is taken.

I hereby authorize the Kentucky Veterans Center to apply for any financial benefits to which I may be entitled.

I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.

Signature of Applicant (or Legal Representative) Date:

Documentary support which must be provided prior to admission includes but is not limited to the following:

- **Medical records from all healthcare providers seen in the six months prior to application and extending to date of admission including recent hospital admissions**
- **Verification of Kentucky residency, (mail items showing current address, utility bills, driver's license, etc.)**
- **Copy of power of attorney/guardianship papers**
- **Copy of living will/advance directives**
- **Copy of discharge from military service, (DD214), or other military document showing dates of service**
- **Copy of military ID, if military retiree**
- **Copy of social security card**
- **Copy of Medicare and/or Medicaid card**
- **Copy of any private insurance cards**
- **Current history & physical, (within past 30 days)**
- **Current medication/treatment list, including herbal and over the counter meds**
- **Current PPD skin test status or proof of negative chest X-ray**
- **Current height and weight**

If the applicant is currently in a nursing facility, please provide the additional information:

- **Nursing monthly summaries**
- **Nursing notes for previous 3 months**
- **MDS Assessment and Care Plan**
- **Social Services notes**
- **Diet information**
- **Current medication list**
- **Immunization records**
- **Skin assessment**
- **Recent lab reports**
- **Proof of all income amounts listed herein.**

FINANCIAL INFORMATION REQUIRED FOR ADMISSION:

- **Verification of ALL GROSS income amounts applicant or spouse receive per month**
- **Income from previous year (pensions, social security, interest, dividends, retirement)**
- **Total out of pocket medical expenses for prior year (Medicare premium, health insurance premium, co-pay for office visits, medications, eye glasses, hearing aids)**
- **Copies of check and check stubs applicant receives for income that is not directly deposited – gross amount before withholding.**
- **Copy of tax return for the previous year, if applicable**
- **Copy of monthly premium paid on supplemental health insurance for applicant and spouse**
- **Copies of last three bank statements for checking and savings accounts**
- **Documentation of Market value of any property other than applicant's primary residence**
- **Documentation of Market value of additional vehicles other than applicant's primary vehicle**
- **Copies of Certificates of Deposit, IRA's, Stocks, Bonds, Money Market Accounts, Life Insurance Policies (cash value) and Burial Funds**
- **Copies of outstanding debts i.e. medical bills, credit cards**
- **Copy of current marriage license**
- **Letter from current nursing or most recent nursing home to verify financial obligation is being met or has been met**

FINANCIAL DISCLOSURE

We thank you for considering Paul E. Patton Eastern Kentucky Veterans Center. To aid us in assessing whether we can meet your financial needs, we would like to review your financial resources to pay for care. Once determined, we can then establish a clear understanding of the financial responsibility you will be undertaking.

We require this information of all residents, regardless of their method of payment or length of stay. Completing this form before admission day will aid us in helping you make the best decisions, and will expedite the admission process. All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information:

Prospective Resident's Name: _____

If you are not the prospective resident:
Your Name: _____ Relationship _____

Prospective Resident's Spouse: _____

Legal Representatives:

Please provide agreements designating each legal representative. (Example: Legal guardian, POA, DPOA, Guarantor, Responsible party)

Type of legal representative* _____

Name: _____ Telephone (day/eve): _____

Address: _____ Title or relationship to resident: _____

Type of legal representative* _____

Name: _____ Telephone (day/eve): _____

Address: _____ Title or relationship to resident: _____

Financial Information:

Does the resident have any insurance that will cover care provided in a long-term care facility?
Yes _____ No ____

If yes, please identify:

Company: _____ Policy #: _____

Address: _____
Agent's Name: _____ Telephone #: _____

Monthly Income:

Salary	$ _____	Social Security check	$ _____
Pension	$ _____	IRA	$ _____
Annuity	$ _____	Disability check	$ _____
Rental income	$ _____	Other	$ _____

Total income – All sources $ _____

Cash Assets:

Bank (1) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ___ If yes, approximate amount $ _____

Bank (2) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ____ If yes, approximate amount $ _____

- Bank (3) _____ Location _____

Checking account # _____ Balance in account $ _____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ____ If yes, approximate amount $ _____

(If there are additional cash assets, which require additional space, please list the location of these assets and the amount on a separate sheet and attach to this financial disclosure.)

Total of all cash assets listed $_____

Real Estate Assets:

Does the resident own a home? No ___ Yes ____ If yes, approximate value $ _____
Does resident own any other property? No ___ Yes _____ If yes, approximate value $ _____

If yes, what and where is property located?

_____

Total value of all properties owned $ _____

Life Insurance Cash value:

Does resident have life insurance policies with cash value? No ___ Yes ___

Company Name: _____ Approximate amount of cash value $ _____

Agent Name: _____ Telephone _____

Annuities $ _____

(If life insurance is held by more than one agent, please list agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Total of all cash values listed $ _____

Securities:

Does the resident have stocks and bonds? No ____ Yes ____

Approximate current market value of all securities $ _____

Agent handling securities _____ Telephone _____

Address: _____

(If more than one agent holds securities, please list these agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Assets Transferred To Or Held In Trust:

Identify assets held in Trust: _____

On what date were assets transferred to Trust?: _____

Approximate value of assets held in Trust: _____

[Require Prospective Resident to Produce Copy of Trust Agreement]

Other:

Are there any other sources of income that have not been identified above?
No _____ Yes ____

Please identify the source(s): _____

_____

Approximate current market value of these sources $ _____

Total available sources of income:

Monthly income	$ _____
Annuities	$ _____
Total sources of income	$ _____ (A)

Total available sources of assets:

Bank (1)	$ _____
Bank (2)	$ _____
Bank (3)	$ _____
Real Estate Assets	$ _____
Life Insurance cash value	$ _____
Securities	$ _____
Other	$ _____
Total Assets	$ _____ (B)

From what source(s) does the resident plan to pay for services at the Facility (named on agreement)?

_____

_____

If necessary, would the resident be willing to liquidate his/her assets to pay for services at the facility?

No ____ Yes ____

If the resident's resources become insufficient to meet total expenses while residing at the Facility, are there other persons or organizations that could help pay for services? If yes, please specify.

_____

_____

Are there any safeguards to ensure that your resources are used only for the resident's benefit? If yes, please specify.

_____

_____

During the past five years, has the resident given or transferred any cash, property or other assets (valued at more than $1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

_____

_____

Who will handle the resident's financial affairs while he/she is a resident at the Facility (named in agreement)?

Name: _____ Relationship _____

Address: _____ Legal Relationship _____

_____ Telephone _____

In the past seven years has the resident declared bankruptcy or had judgments against them?
No ____ Yes ____

If yes, please specify: _____

_____

Liabilities:

Please list any balance owed by the resident on the items below:

House Loans $ _____ Medical Expenses:

Credit Cards $ _____ Doctor $ _____

Automobiles $ _____ Prescriptions $ _____

Notes $ _____ Hospital $ _____

Total Liabilities $ _____ (C)

Estimate of residual assets:

Monthly Income $ _____ (A)

Total Assets $ _____ (B)

- Total Liabilities $ _____ (C)

Residual Assets $ _____

Authorization:

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the center. I authorize the Facility (named in the agreement) to investigate financial and credit records through any investigative or credit agency(s) of it's choice.

Resident: _____ Date: _____

Legal Representative: _____ Date: _____

Legal Guardian, POA, DPOA

Responsible Party/Agent: _____ Date: _____

Facility Representative: _____ Date: _____

Witness*: _____ Date: _____

Witness*: _____ Date: _____

*** Required only if resident is unable to sign his/her full name.**

OMB Number: 2900-0180
Estimated Burden: 3 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 34VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 3 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

DRUG ABUSE | ALCOHOLISM OR ALCOHOL ABUSE | TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) | SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY | COPY OF OUTPATIENT TREATMENT NOTE(S) | OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.